I. Subpart J--Allowable Waivers: General Provisions

1. Basis, scope, and applicability (§457.1000).

This subpart interprets and implements the requirements for a waiver under section 2105(c)(2)(B) to permit a State to exceed the 10 percent limit on expenditures as specified in section 2105(c)(2)(A), and for a waiver to permit the purchase of family coverage under section 2105(c)(3) of the Act. This subpart applies to a separate child health program and to a Medicaid expansion program only to the extent that the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery system.

Comment: One commenter noted that there appears to be a word missing in §457.1000(c). The sentence ends with "seeks a waiver of limitations such claims in light of a community-based health delivery system." The commenter believes that "on" should be inserted after "limitations," although the meaning is still unclear.

Response: We have corrected §457.1000(c), as suggested by the commenter, by adding the word "on". We have also edited the sentence for clarity. The first part of the sentence now indicates that the requirements of this subpart apply to a separate child health program. The second part of the sentence clarifies that the requirements of this subpart also apply for

States that operate Medicaid expansion programs if the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for cost-effective coverage through a community-based health delivery system.

Comment: One commenter suggested that the same time frames for HCFA approval that are proposed for State plan and State plan amendment approvals be included for waivers.

Response: We have amended the regulation text by adding a new §457.1003 to clarify that we will review the waivers under this subpart as State plan amendments under the time frames as specified in §457.160. In practice, State proposals for these waivers have been reviewed as part of the initial State plan or amendment and within the 90-day review period permitted under statute. These waivers must be reflected in the State plan and updated accordingly. It should be noted that the 90-day time frame for review does not apply to HCFA review of section 1115 demonstration proposals under this title.

2. Waiver for cost-effective coverage through a community-based health delivery system (**§**457.1005).

Section **§**457.1005 interprets and implements section 2105(c)(2)(B) of the Act regarding waivers authorized for cost-effective alternatives. In §457.1005, we proposed requirements for a State wishing to obtain a waiver of the 10 percent limit on expenditures not used for child health assistance in the form of

health benefits coverage that meets the requirements of §457.410. This section also clarifies the extent to which the State will be allowed to exceed the 10 percent limitation on such expenditures in order to provide child health assistance to targeted low-income children under the State plan through cost-effective, community-based health care delivery systems.

To receive payment for cost-effective coverage through a community-based health delivery system under an approved waiver, we proposed that the State must demonstrate that--

- Such coverage meets the coverage requirements of section 2103 of the Act and subpart D of this part; and
- The cost of coverage through the community-based health care delivery system, on an average per child basis, does not exceed the cost of coverage that would otherwise be provided under the State plan.

We noted in the preamble to the proposed rule that a State may define a community-based delivery system to meet the specific needs and resources of a community, as long as it ensures that its community-based delivery system (either through direct provision or referral) can provide all appropriate services to targeted low-income children in accordance with section 2103 of the Act. We also proposed that all community-based providers must comply with all other title XXI provisions.

We proposed that an approved waiver will remain in effect

for two years and that a State may reapply three months before the end of the two-year period. We also proposed that, notwithstanding the 10 percent limit on expenditures described in §457.618, if the cost of coverage of a child under a community-based health delivery system is equal to or less than the cost of coverage of a child under the State plan, the State may use the cost savings for--

- Child health assistance to targeted low-income children and other low-income children other than the required health benefits coverage, health services initiatives, and outreach; or
- Any reasonable costs necessary to administer the State Children's Health Insurance Program.

Comment: One commenter suggested that HCFA adopt the definition of "health services initiatives" set forth in the August 6, 1998 letter to State Health Officials. In the letter, the term is defined as "activities that protect the public health, protect the health of individuals or improve or promote a State's capacity to deliver public health services and/or strengthens resources needed to meet public health goals." In addition, the commenter suggested that the preamble make clear that all immigrant children, regardless of their status or date of entry, can participate in, and benefit from, health services initiatives.

Response: We agree with the commenter. We have added the

definition of “health services initiatives” as set forth in the August 6, 1998 letter to the definitions section of the regulations text at §457.10. We note that this definition of health services initiatives includes “other low-income children,” which can include immigrant children, regardless of their status or date of entry, and children who are eligible for Medicaid but not enrolled. As specified in our January, 14, 1998 letter to State Health Officials, health services initiatives may benefit the health of all low-income children, including but not limited to children eligible to receive services under title XXI. Therefore, health services initiatives such as health education activities, school health programs and direct services (such as newborn hearing and lead testing programs), could be targeted to low-income, immigrant communities.

Comment: One commenter proposed that States be permitted to use title XXI funds under this waiver to pay for primary care services provided by community-based providers to children who are not targeted low-income children eligible for the State’s title XXI program, in order to increase access to medically necessary primary care for uninsured SCHIP-eligible children who are not yet enrolled in the State’s title XXI program.

Response: States may provide primary care services to children who are not targeted low-income children through a “health services initiative under the plan for improving the

health of children (including targeted low-income children and other low-income children)." These expenditures would be subject to the 10 percent limit as specified in section 2105(c)(2)(A), except to the extent that the State pays for these services through the use of savings from the waiver for a cost-effective alternative delivery system. In this case, the State could use the savings for primary care services for unenrolled low-income children and those expenditures would not be subject to the 10 percent cap.

Another option for States to consider is using this waiver in conjunction with presumptive eligibility (provisional enrollment). The costs associated with a period of provisional enrollment are benefit costs when the child subsequently is determined eligible for either Medicaid or a separate child health program. However, the costs associated with a period of provisional enrollment for a child who is later determined ineligible for either Medicaid or a separate child health program are costs that are normally subject to the 10 percent limitation. When services are provided during a period of provisional enrollment to a child who is low-income and whom the State later determines to be ineligible for either Medicaid or a separate child health program, the costs of providing benefits to these low-income, ineligible children could be funded through the use of the waiver for a cost effective alternative delivery system.

Again, the benefits provided would have to meet all the requirements of §457.410.

Comment: One commenter suggested allowing States to set aside a portion of their title XXI allotment for a community-based provider program. The commenter noted 90 percent of the set-aside funds would pay for services to SCHIP eligible children and 10 percent of the set-aside funds would pay for administration.

Response: The Act does not dictate how States set their budgets generally or set budget priorities relating to community-based waiver programs. Section 2105(a) authorizes the Secretary to pay a State from its allotment based upon actual expenditures for child health assistance. The State might be able to make expenditures according to the proportions described above. However, as specified in section 2105(c)(2)(A), the amount of administrative expenditures that a State can claim is directly tied to the amount of expenditures they claim for child health assistance.

Comment: One commenter believed that the language in section §457.1005(b)(2) is unclear and asked whether the "State plan" referred to is the Medicaid State plan or the SCHIP State plan.

Response: The waiver described in proposed §457.1005(b)(2) is a program waiver under title XXI and, therefore, the State

plan referred to in this section is the title XXI State plan, as defined in §457.10.

Comment: One commenter recommended amending §457.1005(b)(1) regarding requirements for obtaining a waiver to incorporate a reference to the cost-sharing protections in subpart E and the various beneficiary protections provided in other subparts of the rule and summarized in §457.995. The commenter was concerned that children receiving care in a community-based health delivery system would not benefit from the consumer protections provided in the regulation, and that States should be not permitted to utilize this waiver as a means of circumventing the protections that are afforded to other SCHIP applicants and enrollees.

Response: As proposed, the regulation text at §457.1005(b) required States obtaining a waiver for cost-effective coverage through a community-based health delivery system to demonstrate that (1) the coverage meets the coverage requirements of section 2103 of the Act and subpart D of this part; and (2) the cost of such coverage, on an average per child basis, does not exceed the cost of coverage under the State plan. In the preamble to the proposed rule, we stated that, for the purposes of a waiver, all participating community-based providers must comply with all other title XXI provisions. On further consideration, we have clarified the policy under the final regulation. Section 457.1005(b)) now requires that, in providing child health

assistance through the waiver, the coverage must meet all the requirements of this part, including subparts D and E. Therefore, the final regulation clarifies that all title XXI protections will apply under a waiver for a community-based delivery system in order to assure that all children receive the same protections regardless of where they receive services.

Comment: One commenter believes that HCFA's example of coverage for a special group, such as children who are homeless or who have special health care needs, does not consider that the care for these children may cost more than the care for the average child. The commenter recommended that HCFA reconsider §457.1005 and provide options for States to proceed with caring for children with special needs in a manner that allows payment above the cost of providing coverage to the "average" child.

Response: Section 2105(c)(2)(B)(ii) of the Act specifies that the cost of coverage through the community-based health care delivery system, on an average per child basis, may not exceed the cost of coverage that would otherwise be provided under the State plan. In an August 6, 1998 letter to State Health Officials, we stated that the amount paid to the community-based delivery system on a Federal fiscal year, per child basis must not be greater than the amount that would otherwise have been paid for that child to receive coverage under title XXI. For example, if the amounts that the State pays health plans under

the State plan reflect the risk entailed in providing care to special needs children (because the State risk adjusts its capitation payments, or because the State provides services to these children on a fee-for-service basis), these above-average costs for the special needs children in fact, will be reflected in the cost-effectiveness calculation. Therefore, the cost-effectiveness calculation required under §457.1005(b)(2) does not preclude the State from adjusting its payments for the care of special needs children to provide for higher payment for such care.

Comment: One commenter applauded HCFA's interpretation of waivers as stated in the proposed rule and agreed with the statement that the purpose of this waiver was to increase health services and not to increase funds for administration.

Response: The preamble of the proposed rule set forth our belief that Congress did not intend that the waiver be used primarily to allow for more administrative spending or spending on outreach services under section 2105 (a)(2). While we appreciate the support of the commenter, we also point out that States do retain flexibility regarding the use of any savings obtained as a result of this waiver pursuant to §457.1005(d).

Comment: A number of commenters recommended that approved waivers should initially remain in effect for three years, to coincide with the time frames at section 2104(e) of the Act for

spending the funding allotment for each year, and to provide time to evaluate the waiver's impact and to demonstrate cost-effectiveness. Following the initial approval period, one commenter recommended that the duration be five years, in keeping with the typical duration of 1115 waivers.

Response: We agree with the commenters' suggestion that a 3-year approval period would coincide with statutory time frames for the expenditure of allotments and provide a more adequate period of time in which to determine cost-effectiveness. Therefore, we have revised §457.1005(c) to provide that the duration of time for which waivers for cost-effective coverage through a community-based health delivery system are approved is three years. We will continue to determine cost-effectiveness upon application and renewal for the waiver. However, we have not accepted the recommendation to extend the waiver period to five years because it is important to assess the cost-effectiveness of community-based health delivery systems on a more frequent basis. We have also revised the regulation at §457.1005 to indicate that a State may reapply for approval 90 days before the end of the three year period for consistency with the 90 day review period that apply to State plan amendments.

3. Waiver for purchase of family coverage (§457.1010).

We proposed that a State must apply for a family coverage waiver when any title XXI funds are used to purchase coverage for

adult family members in addition to targeted low-income children. We proposed at §457.1010 that a waiver for family coverage will be approved by the Secretary if--

- Purchase of family coverage is cost-effective under the standards described in §457.1015 of this subpart;
- The State does not purchase such coverage if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage; and
- The coverage for the child otherwise meets the requirements of this part.

We requested comments on whether the benefits specified in title XXI also apply to adults covered by a family coverage waiver. For example, if a State offers "wraparound coverage" to bring an employer's benefits up to the title XXI standards, we solicited comments as to whether the State should be required to offer this additional coverage to adults under the family waiver.

We noted that there is no statutory definition of family coverage for the purposes of this subpart and we solicited input from commenters on the definition of "family" for purposes of this subpart.

Comment: Many commenters questioned whether States covering parents of SCHIP children through a family coverage waiver must provide the benefits specified in title XXI to the family members

who would not otherwise be eligible for SCHIP coverage. These commenters asserted that this decision should be left to State discretion. Commenters did not believe that there is any statutory basis for such a rule. Commenters also indicated that such a requirement would dramatically restrict States' ability to achieve cost-effectiveness in family coverage and would result in a reduction in the number of children that could be insured through the program. Commenters also noted that such a requirement could further complicate the States' administration of benefit and/or cost-sharing upgrades for premium assistance programs because of the difficulty in administering benefit upgrades.

Response: We appreciate the commenters' consideration of this issue, but disagree with the recommendation and rationale because we do not believe it gives weight to the congressional interest in a standard minimum benefit package for all covered individuals. Congress clearly intended that title XXI funds be used to provide a comprehensive benefit package meeting the requirements of section 2103. Children's benefits under a premium assistance program must meet requirements in section 2103, and benefits offered under group health plans typically do not differ for adults and children. In addition, title XXI provides considerable flexibility for States to choose a benchmark package against which they can compare the benefits

offered under a group health plan. Therefore, we have decided to require that any health benefits coverage provided under a family coverage waiver must comply with the benefit requirements of §457.410 and have revised the language at §457.1010(c) to reflect this change.

Section 2105(c)(3)(A) provides the authority for this policy because it requires that the purchase of family coverage must be cost-effective relative to the amounts that the State would have paid to obtain "comparable coverage" for only the targeted low-income children involved. Therefore, this provision clearly contemplates that the coverage offered to non-eligible family members under a family coverage waiver would be comparable to the coverage that would be offered to targeted low-income children. We believe that requiring the family coverage to meet title XXI standards best assures this comparability and is most consistent with the intended use of title XXI funds. However, we have interpreted the statute's use of the term "comparable" to permit the coverage of non-SCHIP eligible family members to be based on a different title XXI benchmark than the targeted low-income children's coverage.

While we recognize the cost of family coverage will increase if the State provides wrap-around coverage to adults in addition to the benefits provided by the group health plan, the degree of cost increase is unclear. For example, when the "wrap-around"

supplemental coverage provided by the State to meet the section 2103 requirements is coverage only for well-baby and well-child services, there would be no additional costs to provide coverage that meets the requirements of section 2103 for adults, because this "wrap-around" coverage is not relevant for adults.

Comment: One commenter stated that it is not clear what would be included in a benefits upgrade for adults. For instance, the commenter questioned if there would need to be a prohibition on cost sharing for adult preventive care visits and services to reflect the statutory prohibitions on copayments or cost sharing for well-baby or well-child care. If this were the case, the commenter indicated that the cost of implementing such a provision would obviously be significant.

Response: While States must ensure that health benefits coverage provided to all family members, including adults, meets the requirements of section 2103, not all benefits are relevant to adult enrollees. For instance, while the statute requires the provision of well-baby and well-child care and prohibits cost sharing for these services, these services are not applicable or available to adults. Therefore, States would not be required to provide coverage to adults for these services, and the specific cost-sharing restrictions applicable to these services also would not apply to adults. However, general cost-sharing limitations do apply to covered services for adults and children under the

family coverage waiver. For example, some States have expressed interest in providing coverage to families above 150% of the FPL and, for this income level, the cumulative cost-sharing maximum of 5% of family income would apply.

Comment: One commenter suggested that HCFA clarify how wrap-around coverage programs could be designed to make family coverage waivers viable, cost effective and simple to administer for group health plans.

Response: We recognize the challenges faced by States in establishing and operating premium assistance programs. The challenges result from the fact that title XXI primarily was designed for targeted low-income children receiving health benefits coverage through programs operated directly by the State, rather than for families receiving health benefits coverage through group health plans. Nonetheless, it is possible to address these challenges. For example, some States are structuring their premium assistance programs to permit direct billing from providers to the State for services or cost sharing that is not covered by the group health plan. In addition, there is flexibility for States to select from among a variety of benchmark benefit packages, and States should carefully consider this flexibility when designing premium assistance programs. We will continue to share new approaches with States as they are developed.

Comment: Commenters encouraged the use of “family” as defined by States, employers, and/or the individual contracting health insurance plans. One commenter believed that States and the Federal government do not need to, and in fact cannot, develop a standard definition. Commenters noted that family coverage waivers will likely be provided through employer-sponsored plans, where the issue of which family members may be included under the employer plan is regulated by contract with insurers and State insurance law. One commenter is planning to submit a request to subsidize employer-sponsored insurance that involves several premium tiers based on which family members are covered and suggests that the definition of “family” include the employee, spouse and children, or employee, and children depending on family composition and the coverage tier selected. Other commenters felt that HCFA should not create a definition of “family,” because such a definition could restrict the ability of group health plans or health insurance issuers from defining what constitutes family coverage. One commenter also noted that a more flexible approach would ease administration and maximize the availability of the family coverage waiver option. Another commenter suggested that the definition be left to State discretion and that once HCFA reviews a wide range of proposals, it can revise the regulations to include a definition if necessary.

Response: We have not defined "family" for the purposes of this regulation in general and, after considering these comments, we agree with the commenters that one standard definition of "family" could unnecessarily restrict States' ability to utilize a family coverage waiver. Therefore, the decision regarding how to define "family" is left to States' discretion.

Comment: One commenter urged that the definition of "family" include adult pregnant women without other family members. The commenter believes that this expansion of the definition is integral to ensuring that all pregnant women have access in their community to readily available and regularly scheduled obstetric care, beginning in early pregnancy and continuing through the postpartum period.

Response: While we support States' efforts to cover pregnant women, title XXI does not support an expansion of coverage to include pregnant women who are not family members of SCHIP-eligible children. Section 2105(c)(3) permits payment to a State for family coverage under "a group health plan or health insurance coverage that includes coverage of targeted low-income children." The statute requires the State to compare the cost of coverage "only of the targeted low-income children involved" with the cost of coverage for the family. A State wishing to cover a pregnant woman who is not a family member of a targeted low-income child would not be able to perform the required cost-

effectiveness test. Therefore, a pregnant woman can be covered through a family coverage waiver only to the extent that a targeted low-income child in her family is eligible for SCHIP coverage.

Comment: A commenter noted that in the preamble to the proposed rule, we stated that States must apply for a family coverage waiver when any title XXI funds are used to purchase coverage for adult family members in addition to targeted low-income children. We also noted that States may purchase coverage for children through premium assistance programs using employer-sponsored insurance without a family coverage waiver when the costs of such children are identifiable. One commenter was concerned that the premium tier structures available to most employers do not permit the costs of children to be identified. The commenter noted that employers offer only two coverage tiers, employee-only and family coverage, which does not permit this kind of determination, because other family members, such as spouses, also may be covered under the family coverage tier. The commenter asserted that the options permitted in the proposed rule for determining the cost of children under employer-sponsored coverage will mean that most States seeking to cover a significant number of uninsured children under a premium assistance program will need to obtain a family coverage waiver.

Because States may wish to utilize employer-sponsored

insurance without subsidizing coverage for the adults in the family, the commenter suggested an alternative method for determining the cost of targeted low-income children covered through employer-sponsored coverage. The commenter proposed that States be permitted to pay a proportion or percentage of the cost of employer-sponsored family coverage without obtaining a family coverage waiver, as long as the portion the State pays is based on a reasonable actuarial estimate of what proportion of the cost of family coverage is attributable to the children, and as long as it meets the cost-effectiveness test.

The commenter suggested that the actuarial determination of the proportion to be paid could be made once a year, based on typical group health coverage plan available in the State, and the percentage could then be applied to the actual premium for family coverage under the specific employer's plan.

Response: We have reconsidered the requirement in the preamble to the NPRM that a family coverage waiver is needed when any title XXI funds are used to provide coverage for adult members of the family. We will not require States to obtain a family coverage waiver in cases where the employee's premium is not subsidized and there is no intention on the part of the State to cover family members other than targeted low-income children. We also agree that the suggestion offered by the commenter appears to offer another possible option for States to identify

the costs of enrolling only the eligible child or children in the family into a premium assistance program, and thereby enroll the children without obtaining a family coverage waiver. As described in the proposed rule, child-only costs can be identified when a State is purchasing a child-only policy, or in markets in which carriers offer policies with a sufficient number of premium tiers to identify the costs of the SCHIP-eligible child or children. Such tiers might include an employee-only premium tier, and an employee-plus-children premium tier, such that the former can be subtracted from the latter to determine the cost of the child or children. However, as the commenter points out, these premium tier structures may not be common or uniformly available in most States.

In a more typical group health insurance market that offers coverage tiers for employee-only or family coverage, the employee contribution amounts for employee-only and for family coverage are known. The difference between the two is the cost for dependent coverage. Again, if title XXI only subsidizes the difference between employee-only and family coverage, a family coverage waiver is not needed as long as there is no intention to cover non-SCHIP eligible family members. However, as an alternate approach, the State could decide to allocate the cost for dependent coverage between the spouse and children on a reasonable actuarial basis and a family coverage waiver would not

be required if the State then pays only that portion allocated to coverage of the targeted low-income child or children. An actuary familiar with the State's group health market could produce an estimate of the cost of one adult relative to the cost for one child under a group health plan. This ratio could then be applied to the family composition to determine what portion of the premium pays for the spouse's coverage and what portion pays for the children's coverage. The State would then pay only that portion attributable to the child or children.

We note, however, that this method may be difficult for States to implement in practice given the need to obtain sufficient data to perform the necessary actuarial estimates. In addition, the subsidy amount determined under this method does not cover the family's full premium cost, which may discourage some families from enrolling. For these reasons, calculating the difference between employee-only and family coverage costs may be a preferable alternative to obtaining actuarial estimates of the costs of only the targeted low-income children for many States. We also note that when a State subsidizes family coverage, but is covering only targeted low-income children (that is, no payment is being made for the employee portion of the premium, and there is no intention to cover family members other than the targeted low-income children and the costs do not exceed the cost-effective amount), the requirements of this part apply to only

the targeted low-income children. We reiterate that family coverage waivers are subject to the same 90-day review period as any other title XXI State plan amendment and need not be unduly burdensome to obtain.

In order to assist States in designing premium assistance programs to cover only targeted low-income children using employer sponsored insurance, we will work with States on their specific proposals to develop mechanisms for identifying the cost of covering the targeted low-income children using reasonable methods, for the purposes of determining cost-effectiveness.

Comment: Several commenters indicated that family coverage waivers will be challenging for States to implement. One commenter expressed concern that the standards for family coverage waivers are impossible to meet and should be made easier to accomplish via a statutory change. Another commenter supported States' interest in developing programs to provide coverage to whole families and urged HCFA to provide more support and technical assistance and to grant more family coverage waivers.

Response: We are committed to sharing best practices and providing guidance to States designing and implementing family coverage waivers and premium assistance programs. To date, three States have received approval for family coverage waivers. As States gain more experience with their premium assistance

programs and their family coverage waivers, we will work to disseminate information about the challenges and successes of these programs.

Comment: A number of commenters were concerned that the proposed regulations are too restrictive regarding when a family coverage waiver is needed. Some noted that, while Congress intended to expand coverage to children, recent research suggests that expanding parents' access to health care coverage also increases children's enrollment, as parents are more likely to apply for and enroll their children in a health insurance program if the whole family is covered by the same plan. They encouraged HCFA to permit States to experiment with both title XIX and title XXI funds to cover parents as an effective strategy to increase enrollment levels of children. They also noted that most States have not spent a significant portion of their title XXI allotments, and may be able to expand coverage further if more flexibility is granted for enrolling parents under title XXI.

Response: We recognize the link between children's enrollment and parental access to SCHIP coverage. We have provided flexibility on this as permitted by the statute. Section 2105(c)(3) sets forth certain requirements relating the coverage of families through a family coverage waiver, and §457.1010 of this regulation implements that section. However, we will continue to work with States that wish to design and

implement programs under a family coverage waiver to help facilitate the enrollment of parents of SCHIP-eligible children in a manner consistent with title XXI.

Comment: One commenter stated that the proposed rule indicates that the community-based waiver applies to Medicaid expansion programs, but the family coverage waiver does not. It is the commenter's opinion that family coverage waivers should be allowed in Medicaid expansion programs.

Response: Family coverage waivers are required whenever States are funding coverage for any non-SCHIP eligible family members with title XXI funds under a separate child health program. Under Medicaid, States are able to purchase employer-sponsored coverage for regular Medicaid and Medicaid expansion enrollees under section 1906 of the Act, which permits States to pay premiums, deductibles, and coinsurance on behalf of Medicaid beneficiaries eligible for enrollment in employer-based group health plans when it is cost-effective to do so. The only exception to this distinction between family coverage in Medicaid expansions and separate child health programs is within the context of our authority under section 1115 of the Act. Section 1115 demonstrations are not subject to regular Medicaid rules when those rules are modified under the Secretary's authority to grant certain waivers, to provide federal funds for costs that would not otherwise be matchable and to impose special terms and

conditions for such demonstrations. In all cases, we are committed to working with States interested in using either funding source, either separately, or in conjunction with each other. As mentioned previously, a family coverage waiver is not needed when the coverage of adult family members is only incidental.

Comment: Several commenters supported coverage of adult family members under family coverage waivers. One commenter supported State flexibility to cover family members but believed that before granting a family coverage waiver, HCFA should ensure that States have utilized their options for expanding health coverage to lower-income adults in non-title XXI funded programs. The commenter notes that HCFA and ACF, in their publication "Supporting Families in Transition," indicated that before expanding coverage under title XXI, States will need to implement a Medicaid expansion under section 1931 of the Act to avoid an anomalous result in which higher income families are covered under SCHIP, while parents of lower-income children lack coverage. Another commenter suggested that HCFA encourage States to apply for Medicaid waivers to expand insurance coverage to adult pregnant women and to facilitate the more rapid enrollment of their infants.

Response: We agree that States' ability to use Medicaid rules to expand coverage to other family members is an important

option, and we have been working with States to clarify the flexibility that exists to do this. Under Medicaid, States may purchase family coverage through employer-sponsored coverage under section 1906 of the Act, which permits States to pay enrollee premiums in employers' group health plans when it is cost-effective to obtain coverage for Medicaid-eligible individuals (deductibles, coinsurance and other cost sharing for ineligible family members may not be paid as medical assistance).

In addition, States may submit proposals for demonstrations under section 1115 of the Act to expand coverage to parents of children covered under SCHIP. HCFA released guidance on July 31, 2000 regarding parameters for consideration of such proposals.

Comment: Several commenters proposed that States should meet prerequisites before receiving approval for family coverage waivers. Some commenters proposed that States must eliminate the asset test under Medicaid and SCHIP and adopt simplified application, enrollment and redetermination procedures for children. Other commenters suggested that States should expand coverage for children with family income up to at least 200 percent of FPL (or 50 percentage points above the State's Medicaid applicable income threshold) throughout the areas of the State; ensure that all eligible children are promptly enrolled into a State's title XXI program without being subject to a waiting list; and, if the State operates a separate child health

program, adopt a joint Medicaid/SCHIP application and assure that the same or directly comparable application, enrollment and redetermination procedure is used for children under Medicaid and the separate State program. Another commenter proposed that States should first be required to ensure that there is no lessening of SCHIP benefits or increase in cost sharing associated with a waiver using this method of calculating cost-effectiveness.

Response: While we support all of these goals, title XXI provides no statutory authority for requiring States to meet these goals prior to the approval of a family coverage waiver. We have been working with States to clarify Federal law and to provide technical assistance regarding the implementation of such policies in order to support States' efforts to undertake activities that will expand and simplify eligibility, increase the number of children who enroll in States' programs, and to make the enrollment and redetermination processes less burdensome on States, applicants and enrollees.

4. Cost-effectiveness (§457.1015).

This section defines cost-effectiveness and describes the procedures for establishing cost-effectiveness for the purpose of a family coverage waiver.

We proposed that cost-effectiveness means that the cost of purchasing family coverage under a group health plan or health

insurance coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining such coverage only for the eligible targeted low-income child or children involved. Stated more simply, cost-effectiveness for the family coverage waiver means that the cost of providing family coverage (including coverage for the parents) is equal to or less than the cost of covering only the SCHIP-eligible children.

We proposed that a State may demonstrate cost-effectiveness by comparing the cost of family coverage that meets the requirements of §§457.1010 and 457.1015 of this subpart, to the cost of coverage only for the targeted low-income child or children under the health benefits packages offered by the State under the State plan for which the child is eligible. Alternatively, we proposed that the State may compare the cost of family coverage to any child-only health benefits package that meets the requirements of §457.410, even if the State does not offer it under the State plan. We stated that we would examine other alternatives and we invited comment on additional methods for demonstrating cost-effectiveness. We set forth an illustration of cost comparison in the proposed rule.

We proposed that the State may demonstrate the cost-effectiveness of family coverage by applying the cost of family coverage for individual families assessed on a case-by-case

basis, or for family coverage in the aggregate. We noted that if a State chooses to apply the cost-effectiveness test on a case-by-case basis, the State must compare the cost of coverage for each family to the cost of coverage for only the child or children in the family under SCHIP. We further explained that if a State chooses to apply the cost-effectiveness test in the aggregate, the State must provide an estimate of the projected total costs of the family coverage program compared to the cost the State would have incurred for covering just the children in those families under the publicly-available SCHIP plan. If the State chooses to assess the cost of family coverage in the aggregate, we also proposed that, on an annual basis, the State must compare the total actual cost of covering all families for whom the State has purchased family coverage to the cost the State would have incurred covering just the children in those families under the publicly-available SCHIP plan. If the aggregate cost of family coverage was less than the cost to cover the children under the publicly available program, then the family coverage would be considered cost-effective. If the State determines through its annual assessment of cost-effectiveness that family coverage is not cost-effective in the aggregate, we proposed that the State must begin to apply the cost-effectiveness test on a case-by-case basis.

Comment: Many commenters indicated that, given the two-year

length of approved waivers, the cost-effectiveness assessment should be done for the life of the waiver.

Response: Section 457.1015 addresses cost-effectiveness for family coverage waivers only, and does not address the cost-effectiveness of waivers for a community-based delivery system. Cost-effectiveness of waivers for a community-based delivery system is determined each time a State applies for or renews its waiver. As stated earlier, we have agreed to extend the period of time for which these waivers are approved from two years to three years.

Family coverage waivers are part of the State plan and are approved for an open-ended period of time after an initial demonstration of cost-effectiveness. However, we will continue to require a State to demonstrate the cost-effectiveness of the family coverage waiver on an annual basis, whether done on a case-by case or aggregate basis, consistent with §457.1015(d). Because we have little information about the costs associated with family coverage waivers, we want to assure that States' premium assistance programs are being administered in the most cost-effective manner possible, and to be able to obtain results so as to share best practices with other States.

We have reconsidered the proposed provision that would have permitted States to conduct its cost comparison against any child-only policy even if it is not offered under the State plan.

The revised language requires that the cost comparison be done relative to the State's actual costs under the State plan in order to assure coverage is provided in the most cost effective manner.

Comment: Several commenters wrote to express support of the rule as written with regard to the cost-effectiveness test. One commenter supported permitting States to perform retrospective cost-effectiveness evaluations but suggested that the cost-effectiveness comparisons should be clarified. Specifically, the commenter indicated that the first example (64 FR 60932) omits any costs for the supplemental coverage that will likely need to be provided and included in the cost-effectiveness test because employer plans may not always cover some services that must be covered under title XXI or exempt well-baby and well-child care from cost sharing.

Response: Although the example in the NPRM did not include the cost of supplemental benefits, the cost of supplemental benefits must be reflected in States' cost-effectiveness analyses. For example, assume the cost to cover two targeted low-income children under the State plan is $200 per month and the cost to cover the family in the employer plan is $120 per month. The State also provides supplemental coverage for benefits and cost sharing that costs $40 per month per family. This $40 would be added to the $120 for a total of $160 which is

still cost-effective in comparison to the $200 that would have been paid under the State plan for only the children. We have also revised the provision at §457.1015 to indicate that cost-effective means that the cost of purchasing family coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining coverage under the plan only for the targeted low-income children involved. We have eliminated the specific reference to the cost paid under a group health plan or health insurance coverage in order to clarify that all costs associated with providing family coverage, including any supplemental coverage, must be considered when determining cost-effectiveness.

Comment: Some commenters believed that because the Department has not developed standards or guidance regarding budget neutrality, State determinations of cost-effectiveness must be accepted and reasonable waivers and family coverage variances should be approved in a timely fashion.

Response: We have clarified the requirements for determining cost-effectiveness under the waiver for cost-effective coverage through a community based delivery system and the waiver for family coverage in both the NPRM and this final rule. Budget neutrality is a relevant consideration with respect to section 1115 demonstration projects, but not with respect to waivers discussed under subpart J. We are committed to working

with States interested in designing and implementing the waivers under subpart J to find the best way possible to comply with these regulations and effectively implement their programs.